SUPPLEMENT F
TECHNOLOGIST FLUOROSCOPY PERMIT APPLICATION
(Summary of RT education and training in the use of fluoroscopy and ancillary equipment.)

Name (last) (first) (middle)

Check (✓) appropriate box(es):

☐ California Diagnostic Radiologic Technology Certificate—number: _____

Topic of Training and Instruction	Hours of Instruction	Date(s) of Training	Instructor's Name
1. Fluoroscopy regulations and radiation safety (account for at least ten hours of training)			
2. Fluoroscopy equipment (account for at least five hours)			
3. X-ray image intensifiers (account for at least four hours)			
4. Television, including closed circuit equipment (account for at least four hours)			
5. Image recording equipment (account for at least six hours)			
6. Special fluoroscopy equipment (account for at least five hours)			
7. Mobile image intensified units (account for at least two hours)			
8. Anatomy and physiology of the eye (account for at least two hours)			
9. Three dimensional and radiological anatomy (account for at least two hours)			

Laboratory Experiments You Have Performed

List all experiments you have performed for each topic listed below.

Methods of reducing dose/exposure to the patient during fluoroscopy procedures:

Methods of reducing exposure to self and personnel:

Image recording during the exposure of a phantom:

Quality control of fluoroscopy equipment:

Use of Fluoroscopy and Ancillary Equipment (Check (✓) equipment with which you have worked and are familiar.)

☐ Conventional fluoroscopy ☐ Closed-circuit TV ☐ Videofluorography

☐ C-arm or U-arm mobile fluoroscopy unit ☐ Image intensifier ☐ Cine

☐ Other (specify): _____

OATH: I hereby attest that to the best of my knowledge, the above is true and accurate.

Applicant signature*	Date
➤	

**** Your signature must be notarized.***

Mail document to: Department of Health Services
Radiologic Health Branch—Certification
P.O. Box 942833, MS 178
Sacramento, CA 94234-2833

FOR DEPARTMENT OF HEALTH SERVICES USE ONLY

Approved by	Date
Approval denied by	Date

Reason for denial:

STATEMENT OF COMPETENCY

To be completed by the applicant's supervising radiologist.

Supervising radiologist's name	California Radiology Supervisor and Operator Certificate number, if applicable	Expiration date

For Out-of-State Applicants

State in which training occurred	Supervising radiologist's name	Medical license number	Expiration date

Supervising Radiologist's Statement

I hereby attest that the following applicant has successfully completed supervised competency based clinical education and training.

Print supervising radiologist name	Print radiologist's name

Name of clinical training facility	Dates of training From: To:

Address of clinical training facility (number, street)	City	State	ZIP code

Training was conducted in the following areas and procedures (please specify procedures):

Gastrointestinal tract

Vascular and angio systems

Orthopedic procedures

Other (please specify)

Supervising radiologist signature	Date

Business telephone number	Fax number
( )	( )